based on angiographic findings in two children.[8,9] Fetterman and Hashida[5] agreed with Tanaka[7] that a clinical resemblance often exists between IPN and MLNS.

In response to careful inquiry, the parents of the infant in the case reported here stated that they knew of no relatives, neighbors or other persons with whom the family has come into contact who had traveled to Japan or Hawaii.

Summary

An infant seen in the San Francisco Bay Area with signs and symptoms suggesting measles was found to have mucocutaneous lymph node syndrome (MLNS) with an additional feature, focal encephalopathy. Therapy with antibiotics, adrenocortical steroids and antihistamine was used. Improvement in the condition of the patient occurred during two and a half weeks in hospital. Anticonvulsant therapy is being continued. Seven months after the onset of the illness no sequelae are evident.

REFERENCES

1. Kawasaki T, Kosaki F, Okawa S, et al: A new infantile acute febrile mucocutaneous lymph node syndrome (MLNS) prevailing in Japan. Pediatrics 54:271-276, 1974

2. Yanagisawa M, Kobayashi N, Matsuya S: Myocardial infarction due to coronary thromboarteritis, following acute febrile mucocutaneous lymph node syndrome (MLNS) in an infant. Pediatrics 54:277-281, 1974

3. Melish ME, Hicks RM, Larson E: Mucocutaneous lymph node syndrome (MCLS) in the U.S. (abstract). Pediatr Res 8:427, 1974

4. Roberts FB, Fetterman GH: Polyarteritis nodosa in infancy. J Pediatr 63:519-529, 1963

5. Fetterman GH, Hashida Y: Mucocutaneous lymph node syndrome (MLNS): A disease widespread in Japan which demands our attention. Pediatrics 54:268-270, 1974

6. Kato H, Koike S, Yamamoto M, et al: Coronary aneurysms in infants and young children with acute febrile mucocutaneous lymph node syndrome. J Pediatr 86:892-898, 1975

7. Tanaka N: Comments on fatal cases of MCLS: Relationship between MCLS and infantile polyarteritis nodosa. Acta Paediatr Japan 76:696, 1972 (cited by Fetterman and Hashida[5])

8. Chamberlain JL III, Perry LW: Infantile periarteritis nodosa with coronary and brachial aneurysms: A case diagnosed during life. J Pediatr 78:1039-1042, 1971

9. McMartin DE, Stone AJ, Franch RH: Multiple coronary artery aneurysms in a child with angina pectoris. N Engl J Med 290:669-670, 1974

Pointers in Antianxiety Pharmacotherapy

A cause for concern is if the condition of a patient is temporarily stabilized on a specific dosage of medication, but he then begins to request an increased dosage. This means to me either worsening of life stresses, deterioration of psychological coping mechanisms (perhaps indicative of a more serious mental disorder), or the developing of abuse and addiction. Sometimes the patient will complain that no tranquilizer he has tried is satisfactory, in any dosage, but may keep demanding a different drug and higher doses. This is also indicative of a serious problem. Keep careful records of all prescriptions written, with notations indicating when the patient should be running out of pills . . . be suspicious if a patient tells you he has run out of medication sooner than your records indicate he should, or if he tells you that he has lost his prescription or lost his pills—particularly if this happens more than once. If it does happen more than once, I am certain he is taking more than what has been prescribed. The patient should be confronted with this problem and be advised to seek professional mental health intervention. Another problem which arises not infrequently is a patient getting tranquilizer prescriptions from more than one physician. Sometimes this is because the patient shops around and keeps it a secret. But other times this is the result of insufficient communication between the family physician and the psychiatrist or mental health agency to which the patient is referred. The patient may openly continue to see the referring physician who continues to prescribe tranquilizers or sleeping pills while the psychiatrist continues to do the same, neither taking the effort to check what the other is doing with the patient. This problem arises in two ways: The referring physician does not call or write the psychiatrist explaining the reason for referral, but instead just sends the patient to present the problem himself; or the psychiatrist does not recontact the referring physician to work out a joint treatment plan.

—RICHARD M. KETAI, MD, *Ann Arbor*

Extracted from *Audio-Digest Family Practice* Vol. 24, No. 12, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1930 Wilshire Blvd., Suite 700, Los Angeles, CA 90057.